Complete Summary

GUIDELINE TITLE

Evidence-based care guideline for chronic care: self-management.

BIBLIOGRAPHIC SOURCE(S)

Chronic Care: Self-management Guideline Team, Cincinnati Children's Hospital Medical Center. Evidence-based care guideline for chronic care: self-management. Cincinnati (OH): Cincinnati Children's Hospital Medical Center; 2007 Mar 9. 32 p. (Guideline; no. 30). [141 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Chronic illness/condition, defined as:

- A medical condition of more than 3 months duration and/or
- Persistent functional limitations; and/or
- Use of healthcare services beyond usual care (beyond resolvable developmental issues—e.g., preschool speech therapy)

GUIDELINE CATEGORY

Counseling
Evaluation
Management

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Nursing
Nutrition
Pediatrics
Physical Medicine and Rehabilitation
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dietitians
Health Care Providers
Nurses
Patients
Pharmacists
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers

GUIDELINE OBJECTIVE(S)

To provide evidence-based recommendations for self-management by families of children with chronic conditions in order to improve health outcomes and quality of life

TARGET POPULATION

Children with chronic conditions and their families

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment

1. Comprehensive assessments and reassessments of the patient's/family health related quality of life and knowledge of disease, treatment plan, and prognosis family functioning and social/environmental context (health risks)
2. Self-management components (health beliefs, readiness to change (motivation), confidence (self efficacy) and importance (priority)

Management

1. Motivational interviewing on health behavior change
2. Shared decision making and decision aids (tools)
3. Written action plans (including goal setting and barrier management)
4. Patient/caregiver education
    - Self-management education and skills building
    - Tailored health education

    - Group-based training and nurse education
    - Peer-led manualized (standardized) education programs
    - Computer-based information packages and/or systematic mailings
5. Family-to-family support
6. Referral to trained professionals
    - Family therapy
    - Stress management
    - Coping skills training
    - Relaxation and cognitive behavioral therapy
    - Behavioral incentives
7. Follow-up (self-management interactions and re-assessments)

MAJOR OUTCOMES CONSIDERED

- Self efficacy
- Health-related quality of life
- Healthcare utilization (e.g., hospital days, unscheduled visits)
- Parent/patient satisfaction
- Missed days from usual activities
- Cost
- Specific disease measures (e.g., pain, peak flow, HbA1c)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

To select evidence for critical appraisal by the group for the development of this guideline, the Medline, EmBase, and the Cochrane databases were searched for dates of January 1970 to June 2006 to generate an unrefined, "combined evidence" database using a search strategy focused on answering clinical questions relevant to Chronic Care Self--Management. A few focused searches were done in late 2006 that additionally included searching the PsychInfo database.

Searches employed a combination of Boolean searching on human-indexed thesaurus terms (Medical Subject Heading [MeSH] headings using an OVID Medline interface) and "natural language" searching words in the title, abstract, and indexing terms. The citations were reduced by: eliminating duplicates, review articles, non-English articles, and adult articles. The resulting abstracts were reviewed by a methodologist to eliminate low quality and irrelevant citations. During the course of the guideline development, additional clinical questions were generated and subjected to the search process, and some relevant review articles were identified.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Delphi)
Expert Consensus (Nominal Group Technique)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The recommendations contained in this guideline were formulated by an interdisciplinary working group which performed systematic and critical literature reviews, using a grading scale, and examined current local clinical practices.

Guideline focus was based on family and healthcare provider feedback using consensus techniques. See related Appendices 4, 5, 6, and 7 in the original guideline document. Self-management (effective management at home) emerged as the priority topic for this guideline.

The following processes and techniques were used to provide focus, direct guideline development and prioritize domains of the Chronic Care Model:

- Delphi Method used with chronic care quality improvement team leaders (nurses, physicians, social workers), parents serving on chronic care quality improvement teams, guideline Team members, and the Family Advisory Council.
- Nominal Group Technique was used with guideline Team members.
- Surveys were completed with families of children and patients experiencing various chronic illnesses.
- A Chronic Care Key Driver Analysis was developed with local chronic care expert groups and quality improvement consultants to identify critical components of the chronic care management process, needs and experience. See Appendix 7 in the original guideline document.

Delphi Method and Nominal Group Technique were employed to achieve consensus for a specific focus area. Delphi Method was accomplished by respondents through computer-based surveys. Several cycles of surveys were completed. Survey responses regarding aspects of care were categorized by theme based on the Chronic Care Key Driver Analysis. Aspects of care were categorized by them independently by the Guideline co-chairs and consensus was achieved. Nominal Group Technique was then used to obtain priority rankings in order to determine the domain of focus of the Chronic Care Model. See Appendix 4 and Appendix 5 in the original guideline document.

Recommendations have been formulated by a consensus process directed by best evidence, patient and family preference and clinical expertise. During formulation of these recommendations, the Team members have remained cognizant of controversies and disagreements over the management of these patients. They have tried to resolve controversial issues by consensus where possible and, when not possible, to offer optional approaches to care in the form of information that includes best supporting evidence of efficacy for alternative choices.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline has been reviewed and approved by clinical experts not involved in the development process, senior management, other appropriate hospital committees, and other individuals as appropriate to their intended purposes.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Each recommendation is followed by an evidence classification (A-S) identifying the type of supporting evidence. Definitions for the types of evidence are presented at the end of the "Major Recommendation" field.

Foundational Care Principles are addressed in recommendations 1 through 4, followed by more specific strategies.

1. It is recommended that the following components of comprehensive chronic care be included for all children and adolescents with chronic conditions:

- Self-management in the home/community
- Case/care management
- Disease specific care management

(Norris et al., "Self-management," 2002 [M]; Norris et al., "The effectiveness," 2002 [M]; Norris et al., "Increasing diabetes," 2002 [M]; Renders et al., 2001 [M]; Wagner et al., 2005 [S]; Task Force on Community Preventive Services, 2002 [S, E]; Drotar et al., 2001 [E])

2. It is recommended that healthcare providers use collaborative communication to promote patient/family-centered health care (Michie, Miles, & Weinman, 2003 [M]; Lewin et al., 2001 [M]; Stewart, 1995 [M]; Wasson et al., "Patients," 2006 [C]; Wasson et al., "Resource planning," 2006 [O]; Task Force on Community Preventive Services, 2002 [S, E])
3. It is recommended that self-management interactions and interventions with patients and families be grounded in cultural competence:
    - Sociocultural factors (e.g., ethnicity, social support structures, economic factors)
    - Literacy level (i.e., use of linguistically appropriate educational materials)
    - Spiritual tradition
    - Gender and age
    - Health beliefs and values
    - Communication (e.g., language barriers)

    (Coffman, 2004 [M]; Betancourt, 2002 [S]; Flores, 2000 [S])

    Note: Cultural influences and preferences affect the dynamics of the physician-patient interaction and the decision-making process (Charles et al., 2006 [S]).

4. It is recommended that healthcare teams have staff trained in the delivery of self-management strategies (Lozano et al., 2004 [A]; Clark et al., 1998 [B]; Lorig & Holman, 2003 [S]; Wagner, Austin, & Von Korff, 1996 [S]; Local Consensus [E]).

    Note 1: Content of healthcare provider education and training to include at a minimum:

    - Assessment skills
    - Motivational interviewing
    - Information sharing
    - Problem solving/goal setting
    - Shared decision making
    - Self efficacy assessment
    - Follow-up interventions

    Note 2: Healthcare provider education on self-management strategies, provided by clinician peer leaders is effective for improving chronic care (Lozano, 2004 [A]; Greene, Yedidia, & The Take Care to Learn Evaluation, 2005 [C]).

Note 3: Self-management training models, programs or resources are listed in Appendix 8 (Local Consensus [E]) and Appendix 9 in the original guideline document (sample algorithm).

The behavior change counseling model known as the **5 A's Cycle (Assess, Advise, Agree, Assist, Arrange)** was adopted for this guideline as a method to organize self-management interventions. See Appendix 3 in the original guideline document. Created from concepts originally identified by (Manley 1991 [E]).

The 5 A's Cycle

Assess

Assess patient's and family's behavior, health beliefs, health status, skills, and knowledge.

5. It is recommended that comprehensive assessments (upon initial diagnosis or early in care management) and reassessments, using validated tools when available, be performed to evaluate the patient's/family's:
    - Health related quality of life
    - Knowledge of disease, treatment plan, and prognosis
    - Family functioning
    - Social/environmental context (health risks)

    (Hauser et al., 1990 [C]; Jacobson et al., 1990 [C]; Hauser et al., 1986 [C]; McQuaid et al., 2005 [O]; Jacobson et al., 1987 [O]; Burroughs et al., 1997 [S])

    Note 1: These assessments will help to identify patients and families at risk for suboptimal health outcomes and poor adherence and help to stratify intensity of care management based on individual patient/family needs and risks (Norris et al, "The effectiveness," 2002 [M]; Dorr et al., 2006 [D]; Farmer et al., 2004 [O]; Burroughs et al., 1997 [S]).

    Note 2: Family conflict, one aspect of family functioning, is a strong predictor of poor adherence among adolescents with diabetes. (Anderson, 1997 [C]; Hauser et al., 1990 [C]).

    Note 3: Samples of assessment tools are found in Appendix 10 in the original guideline document. Clinicians are encouraged to evaluate the validity and reliability of tools prior to their use with specific populations and/or settings. A suggested list of criteria to assess tool validity is found in Appendix 11 in the original guideline document.

6. It is recommended that the following self-management components be assessed and documented:
    - Health beliefs
    - Readiness to change (motivation) using a visual numeric scale
    - Confidence (self efficacy) using a visual numeric scale
    - Importance (priority) using a visual numeric scale

(see Appendix 12 in the original guideline document)

(Littlefield et al., 1992 [C]; Hauser et al., 1990 [C]; Jacobson et al., 1990 [C]; Hauser et al., 1986 [C]; Hesse, 2006 [O]; Lorig et al., 1989 [O]; Jacobson et al., 1987 [O]; Lorig & Holman, 2003 [S]; Rollnick, Mason, & Butler, 1999 [E]; Local Consensus [E]).

Note 1: Subject ratings of confidence (self efficacy) were found to consistently predict subsequent health related outcomes. (Holden, 1991 [M]).

Note 2: These particular assessment components have been found to be helpful in customizing strategies in facilitating healthy behavior change.

Note 3: Samples of assessment tools can be found in Appendix 10 in the original guideline document.

Advise/Counsel

Counsel patients/families by providing specific information about health risks and benefits of change.

7. It is recommended that motivational interviewing be used to counsel patients/families on health behavior change (Hettema, Steele, & Miller, 2005 [M]; Rubak et al, 2005 [M]; Dunn, Deroo, & Rivara, 2001 [M]; Lewin et al., 2001 [M]; Butler et al., 1999 [A]; Monti et al., 1999 [B]; Colby et al., 1998 [B]; Erickson, Gerstle, & Feldstein, 2005 [S]; Miller & Rollnick, 2002 [E]; Rollnick, Mason, & Butler, 1999 [E]).

   Note 1: Motivational interviewing is a patient-centered, directive method of communication used throughout self-management support with the goal of enhancing motivation to change behavior by exploring and resolving ambivalence (Miller & Rollnick, 2002 [E]).

   Note 2: Motivational interviewing is effective in brief encounters and produces better outcomes in management of unhealthy behaviors than traditional advice giving or confrontation when addressing self-management support (Rubak et al., 2005 [M]).

   Note 3: The Elicit-Provide-Elicit method is a motivational interviewing technique to structure the process for counseling patients and families in the context of a brief office visit and is found in Appendix 13 of the original guideline document (Mash & Allen, 2004 [O]; Gance-Cleveland, 2005 [S]; Rollnick, Mason, & Butler 1999 [E]).

8. It is recommended that shared decision making and decision aids (tools) be used regarding intervention options (O'Connor et al., 2003 [M]; Charles et al., 2006 [S]).

   Note 1: See sample generic decision aid tools on the web: http://decisionaid.ohri.ca/AZsearch.php?Topic=Any_decision and

http://www.dhmc.org/webpage.cfm?site_id=2&org_id=108&gsec_id=0&sec_id=0&item_id=2486.

Note 2: Shared decision making is especially beneficial when there is no clear "best" treatment option.

Note 3: Shared decision aids produce increased confidence, knowledge, and optimism, congruence with treatment, and improved involvement in making choices regarding care options (O'Connor et al., 2003 [M]).

Agree

Agreement on goals that are collaboratively set based on patient's/family's level of importance (priority) and confidence (self efficacy) in their ability to change the behavior.

9. It is recommended that written action plans including goal setting and barrier management be used to assist patients/families in planning for behavioral change, customizing them to address:
    - Individual needs
    - Patient characteristics
    - Developmental level of the child
    - Patient preferences
    - Available resources

    (Haynes et al., 2005 [M]; Gibson et al., 2004 [M]; Haby et al., 2001 [M]; Toelle & Ram, 2002 [M]; Powell & Gibson, 2003 [M]; Wolf et al., 2003 [M]; Staab et al., 2006 [A]; Local Consensus [E])

    Note 1: There is no consistent evidence that written plans alone produced better patient outcomes than no written plan. However, comprehensive care that includes education, a written self-management plan, and regular review has been shown to improve outcomes. (Gibson et al., 2002 [M]; Toelle & Ram, 2002 [M]).

    Note 2: The "My personal action plan" tool, found in Appendix 14 in the original guideline document, is one that could be used to implement this recommendation. (Local Consensus [E]).

Assist

Assist patients/families to problem solve by identifying personal barriers; strategies; social, environmental, and community support and resources.

10. It is recommended that self-management education and skills building be integrated into the care of all patients/families at the developmentally appropriate level (Gibson et al., 2002 [M]; Wolf et al., 2003 [M]; Fireman et al., 1981 [C]; Task Force on Community Preventive Services. 2002 [S, E]; Betz, 2000 [S]).

Note 1: Self-management education of patients and families reduces the number of hospitalizations, emergency and unscheduled visits, and missed work and school days. (Gibson et al., 2002 [M])

Note 2: Patient education alone is not sufficient to promote health behavior (Norris et al., 2006 [M]; Haby et al, 2001 [M]; Bartholomew et al., 1991 [O]).

Note 3: See Appendix 15 in the original guideline document for possible self-management supports at various developmental stages.

11. It is recommended that self-management education and skills building include tailored health education based on individual patient/family needs, risks, and readiness to change (Norris et al., "The effectiveness," 2002 [M]; Dorr et al., 2006 [D]; Farmer et al., 2004 [O]; Local Consensus [E]).

    Note: In randomized trials of smoking cessation interventions, tailored educational materials had the most significant impact on behavior change (Lancaster & Stead, 2002 [M]).

12. It is recommended that education on self-management skills building be provided through a range of individual and/or group sessions within a variety of community settings (e.g., homes, schools, churches, camps, and worksites) beyond an office visit (Deakin et al., 2005 [M]; Gibson et al., 2002 [M]; Norris et al., "Increasing," 2002 [M]; Evans et al., 2001 [A]; Resnicow et al., 2001 [A]; Lorig et al., 1999 [A]; Hederos, Janson, & Hedlin, 2005 [B]; Fireman et al., 1981 [C]; Glasgow et al., 2004 [S]).

    Note 1: Group-based training and nurse education improve effective home management (reduces symptoms, exacerbations, school absenteeism, and number of hospitalizations and emergency room visits) (Fireman et al., 1981 [C]).

    Group-based self-management education has been shown to decrease both healthcare costs and resource utilization while improving health outcomes (Deakin et al., 2005 [M]; Hederos, Janson, & Hedlin, 2005 [B])

    Note 2: Heterogeneous patient groups are feasible and beneficial beyond usual care, can improve health outcomes, and may result in more effective use of resources (Lorig et al., 1999 [A]).

    Note 3: Self-management and written health education materials which were administered and brought home from school positively influenced parent's and children's self-management of their child's asthma (Evans et al., 2001 [A]; Evans et al., 1987 [C]).

13. It is recommended that peers (parents, patients, or lay experts) be involved in the delivery of self-management education programs (Chernoff et al., 2002 [A]; Von Korff et al., 1998 [A]; Anderson et al., 1989 [B]; Lorig et al., 1986 [B]; Lorig et al., 2001 [C]; Cohen et al., 1986 [C]; Story, et al. 2002 [O]).

Note: Peer-led manualized (standardized) education programs for promoting self-management of chronic disease have been found to improve health outcomes, increase patient/family support, while reducing healthcare costs and resource utilization in diverse populations and have been shown to be as effective as those led by healthcare providers (Von Korff et al., 1998 [A], Lorig et al.,1986 [B]; Lorig et al., 2001 [C]; Cohen et al., 1986 [C]).

14. It is recommended that computer-based information packages for patients and/or systematic mailings be used to enhance self-management education (Kroeze, Werkman, & Brug, 2006 [M]; Murray et al., 2005 [M]; Lorig et al. 2004 [A]; Lorig et al., 2002 [A]; Glasgow et al., 1997 [A]; Horan et al., 1990 [B]).

    Note 1: Computerized information packages for patients have been termed Interactive Health Communication Applications (IHCAs) and have been found to:

    - Provide health information (increase knowledge)
    - Enable informed decision making
    - Promote healthy behaviors
    - Promote peer support (increase social support)
    - Manage demand for health services
    - Improve health outcomes

    (Murray et al., 2005 [M]).

    Note 2: Computer-assisted assessment that provides immediate feedback on key barriers to self-management, goal setting, and problem-solving counseling has been found to improve health behavioral change and outcomes (Glasgow et al., 1997 [A]).

    Note 3: Systematic mailings improve role function, decrease disability and improve self efficacy and decrease the human resource cost of delivering this information (Lorig et al., 2004 [A]).

15. It is recommended that the following self-management tools/interventions be incorporated into self-management support:
    - Self monitoring (diaries, journals)
    - Action planning (written action plans)
    - Collaborative problem solving
    - Regular practitioner review/follow up

    (Kroeze, Werkman, & Brug, 2006 [M]; Gibson et al., 2002 [M]; Powell & Gibson, 2003 [M]; Renders et al., 2001 [M]; Lozano et al., 2004 [A]; Von Korff et al., 1998 [A]; Wasson et al., "Patients," 2006 [C]; Wasson et al., "Resource planning," 2006 [O]; Glasgow et al., 2002 [O]).

16. It is recommended that family-to-family support be included as an integral component of care and that "experienced" patients/families be empowered to deliver these interventions (Chernoff et al. 2002 [A]; Ritchie et al. 2000 [A];

Von Korff et al., 1998 [A]; Hederos, Janson, & Hedlin, 2005 [B]; Lorig et al., 1986 [B]; Cohen et al., 1986 [C]; Burroughs et al. 1997 [S]).

Note 1: Family-to-family support has been shown to decrease anxiety and worry in caring for children with chronic health conditions (Ireys et al., 2001 [S]).

Note 2: Examples of family support interventions may include family-to-family networking, parent mentoring, web-based communication, patient/family newsletter, and/or parent advisory teams.

17. It is recommended that children, adolescents, and their families be referred to trained professionals to implement any of the following interventions:
    - Family therapy
    - Stress management
    - Coping skills training
    - Relaxation and cognitive behavioral therapy
    - Behavioral incentives

    (Yorke, Fleming, & Shuldham, 2005 [M]; Eccleston et al., 2003 [M]; Lemanek, Kamps, & Chung, 2001 [M]; Kashikar-Zuck et al., 2005 [B]; Burkhart et al., 2002 [B]; Degotardi et al., 2005 [C])

    Note 1: These techniques have been shown to be effective in the management of patients with chronic pain, headache, and asthma (Yorke, Fleming, & Shuldham, 2005 [M]; Eccleston et al., 2003 [M]).

    Note 2: Intense family therapy has been shown to improve outcomes in adolescents with poorly controlled insulin-dependent diabetes (Ellis et al., 2005 [B]).

    Note 3: Behavioral Family Systems Therapy (BFST) has been shown to improve diabetic outcomes, parent and adolescent relationships, and treatment adherence (Wysocki et al., 2000 [A]; Wysocki et al., "Effects," 2006 [A]; Wysocki et al., "Behavioral assessment," 2006 [S]).

    Note 4: Behavioral incentives (e.g., praise, stickers, special activities, toys, games, gift certificates, or monetary rewards) have been shown to improve treatment adherence in children with chronic illness (Lemanek, Kamps, & Chung, 2001 [M]).

Arrange

Determine and arrange for a specific follow-up plan.

18. It is recommended that self-management interactions and re-assessments occur on a regular, structured basis (Haynes et al., 2005 [M]; Gibson et al., 2002 [M]; Powell & Gibson, 2003 [M]; Renders et al., 2001 [M]; Hauser et al., 1990 [C]; Jacobson et al., 1990 [C]; Hauser et al., 1986 [C]; Jacobson et al., 1987 [O]).

Note 1: Available evidence does not well define the optimal level of intensity or frequency for these interactions. In one meta-analysis of adults with type 2 diabetes, increased contact time between educator and patient was the only significant predictor of improved glycemic control (Norris et al., "Self-management," 2002 [M]).

Note 2: Evidence indicates that decreased intensity or frequency of clinical review may negatively impact the effectiveness of self-management (Powell & Gibson, 2003 [M]).

Note 3: Frequent contacts (email, phone, office visit) between provider and patient/family are an effective method of enhancing adherence. More complex interventions do not necessarily produce better outcomes (Haynes et al., 2005 [M]).

Definitions:

Cincinnati Children's Hospital and Medical Center Grading Scale

M: Meta-analysis
A: Randomized controlled trial: large sample (n >100)
B: Randomized controlled trial: small sample (n <100)
C: Prospective trial or large case series
D: Retrospective analysis
O: Other evidence
S: Review article
E: Expert opinion or consensus
F: Basic laboratory research
Q: Decision analysis

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and classified for each recommendations (see "Major Recommendations") using the following scheme:

Evidence Grading Scale

M: Meta-analysis
A: Randomized controlled trial: large sample (n >100)
B: Randomized controlled trial: small sample (n <100)

C: Prospective trial or large case series
D: Retrospective analysis
O: Other evidence
S: Review article
E: Expert opinion or consensus
F: Basic laboratory research
Q: Decision analysis

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate self management of chronic conditions to improve health outcomes and quality of life

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Some cited evidence is based on adult populations that were determined to be applicable as it relates to interactions with parents and families.

For the purpose of this guideline, chronic illness is defined as:

- A medical condition of more than 3 months duration and/or
- Persistent functional limitations; and/or
- Use of healthcare services beyond usual care (beyond resolvable developmental issues – e.g. preschool speech therapy).

These recommendations result from review of literature and practices current at the time of their formulations. This guideline does not preclude using care modalities proven efficacious in studies published subsequent to the current version of this document. This document is not intended to impose standards of care preventing selective variances from the recommendations to meet the specific and unique requirements of individual patients. Adherence to these recommendations is voluntary. The physician in light of the individual circumstances presented by the patient must make the ultimate judgment regarding the priority of any specific procedure.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Quick Reference Guides/Physician Guides
Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Chronic Care: Self-management Guideline Team, Cincinnati Children's Hospital Medical Center. Evidence-based care guideline for chronic care: self-management. Cincinnati (OH): Cincinnati Children's Hospital Medical Center; 2007 Mar 9. 32 p. (Guideline; no. 30). [141 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2007 Mar 9

GUIDELINE DEVELOPER(S)

Cincinnati Children's Hospital Medical Center - Hospital/Medical Center

GUIDELINE DEVELOPER COMMENT

As facilitated by the Health Policy & Clinical Effectiveness Department of the Cincinnati Children's Hospital Medical Center.

SOURCE(S) OF FUNDING

Cincinnati Children's Hospital Medical Center

GUIDELINE COMMITTEE

Chronic Care: Self-Management Guideline Team 2007

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Cincinnati Children's Hospital Medical Center Physicians: Janalee Taylor, RN, MSN, CNS, Co-Chair, Advanced Practice Nurses; Anita Schambach, RN, MS, BCIAC, Co-Chair, Ancillary Services; Maria Britto, MD, MPH, Div. of Adolescent Medicine; Karen Burkett, RN, MSN, CNP, Ctr. For Professional Excel & Rsch/EBP; Tammy Dimuzio, RN, MS, CDE, A3S Outpatient Diabetes/Endo/CRC; Wendy Gerhardt, RN, MSN, Patient Services; Susmita Kashikar-Zuck, PhD, Behavioral Med & Clinical Psychology; Avani Modi, PhD, Behavioral Med & Clinical Psychology; Dawn Nebrig, LISW, MSW, Clinical Development & Education; Dave Pruitt, MD, Div. of Physical Medicine & Rehabilitation; Judy Ragsdale, M.Div, ACPE, Clinical Pastoral Education; Heather Rolke, RN, BSN, A6 Inpatient Unit – Adolescent; Thomas Webb, MD, Div of Development & Behavioral Pediatrics; Jeanne Weiland, RN, MSN, CNS, Advanced Practice Nurses

Division of Health Policy & Clinical Effectiveness Support: Eduardo Mendez, RN, MPH, Dir. Evidence-Based Care, Facilitator; Edward Donovan, MD, Medical Director, Clinical Effectiveness; Danette Stanko-Lopp, MA, MPH, Epidemiologist; Carol Tierney, RN, MSN, Education Coordinator; Eloise Clark, MPH, MBA, Guideline Program Administrator; Darrin Hooks, Administrative Assistant

All Team Members and Clinical Effectiveness support staff listed above have signed a conflict of interest declaration.

Ad hoc Advisors: Barbarie Hill, MA, AHIP, Manager, Pratt Library; Cheryl Hoying, RN, PhD, Sr. V.P., Patient Services; Uma Kotagal, MBBS, MSc, Sr. V.P., Quality and Transformation; Laura Werts, BS, CMP, CME Coordinator

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

This guideline was developed without external funding. All Team Members and Clinical Effectiveness support staff listed have declared whether they have any conflict of interest and none were identified.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Cincinnati Children's Hospital Medical Center.

Print copies: For information regarding the full-text guideline, print copies, or evidence-based practice support services contact the Children's Hospital Medical

Center Health Policy and Clinical Effectiveness Department at HPCEInfo@chmcc.org.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Chronic care: self management. Guideline highlights. Cincinnati (OH): Cincinnati Children's Hospital Medical Center; 2007 Feb 20. 1 p. Electronic copies: Available in Portable Document Format (PDF) from the Cincinnati Children's Hospital Medical Center Web site.
- Evidence-cased care guideline development and update process. Cincinnati (OH): Cincinnati Children's Hospital Medical Center; 2006. 35 p. Electronic copies: Available in Portable Document Format (PDF) from the Cincinnati Children's Hospital Medical Center Web site.

Additionally, a variety of implementation tools, including a sample algorithm for initiating self-management, samples of assessment tools, criteria to assess the validity of an assessment tool, and a self-management personal action plan are available in the appendices of the original guideline document.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on June 14, 2007. The information was verified by the guideline developer on July 2, 2007.

COPYRIGHT STATEMENT

Notification of CCHMC at HPCEInfo@cchmc.org for any EBCG adopted, adapted, implemented or hyperlinked to by a given organization and/or user, is appreciated.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 9/22/2008